U.S. Department of Labor

Office of Administrative Law Judges
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Date Issued: February 7, 2001

Case No: 1984-BLA-4271

In the Matter of

RAGON CUNNINGHAM (Deceased),

Claimant,

v.

ISLAND CREEK COAL COMPANY,

Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:

Darlene Robinson, Esquire
For the claimant

Natalie D. Brown, Esquire
For the employer

BEFORE: DONALD W. MOSSER
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act

of 1972 and the Black Lung Benefits Reform Act of 1977, 30 U.S.C. § 901 et seq. (the Act). In a case involving a living coal miner, benefits are awarded under the Act to a claimant who is totally disabled within the meaning of the Act due to pneumoconiosis arising out of coal mine employment. Pneumoconiosis is defined in the Act as a dust disease of the lungs arising from coal mine employment and the disease is commonly known as black lung.

Following proper notice to all parties, a formal hearing was held in regard to this claim on April 20, 2000 at Evansville, Indiana. The Director's exhibits were offered in evidence at the hearing pursuant to 20 C.F.R. § 725.456, and the parties were afforded the opportunity to present additional evidence. Counsel also were allowed to submit post-hearing briefs.

The findings of fact and conclusions of law set forth in this decision are based upon my analyses of the entire record and my observation of the demeanor of the witness who testified at the hearing. Each exhibit and argument of the parties, although perhaps not specifically mentioned, has been carefully reviewed and thoughtfully considered. Where the contents of certain medical evidence in the record appear inconsistent with the conclusions reached in this decision, it should be considered that the appraisal of the relative merits of each item of medical evidence has been conducted in conformance with the quality standards of the regulations.

Section numbers hereinafter cited exclusively pertain to Title 20, Code of Federal Regulations. References to DX and EX pertain to the exhibits of the Director and employer, respectively. The transcript of the hearing is cited as Tr. and by page number.

ISSUES

The following controverted issues remain for decision:

1. whether Mr. Cunningham had pneumoconiosis as defined by the Act and regulations;

2. whether his pneumoconiosis arose out of coal mine employment;

3. whether he was totally disabled;

4. whether his disability was due to pneumoconiosis; and,

5. whether the evidence establishes a change in conditions or a mistake in a determination of fact within the meaning of Section 725.310.

(DX 100; Tr. 11).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

The claimant, Ragon Cunningham, was born on June 6, 1922. He married Minnie Lovell on May 4, 1940 and she remained his dependent on the date Mr. Cunningham filed his claim. The claimant died on January 2, 1998. Mr. Cunningham claimed no other dependents on his application for benefits. (DX 1, 4).

Mr. Cunningham filed the claim involved in this proceeding on May 23, 1982. An administrative law judge of the U.S. Department of Labor initially awarded benefits to the miner on May 14, 1987. The employer appealed the decision on May 27, 1987 and the Benefits Review Board (Board) issued an order of remand on May 31, 1989 vacating the administrative law judge's May 14, 1987 decision and order. Subsequently, on remand, the judge again awarded benefits to the claimant on June 7, 1991. The employer again appealed this decision on July 5, 1991.

On July 29, 1993, the Board affirmed the decision in part, vacated it in part, and remanded the case for further consideration consistent with its opinion. On November 18, 1993, because the original administrative law judge was no longer available to decide the case, the case was transferred to another administrative law judge. On January 20, 1994, that judge issued a second decision and order on remand, denying benefits to the claimant. On January 26, 1994, the claimant appealed the decision. The Board issued a decision on May 30, 1995 affirming the administrative law judge's January 20, 1994 decision which denied benefits to Mr. Cunningham. On July 3, 1995, the claimant requested a modification of the denial.

After submission of additional medical evidence by the claimant, the district director again denied the claim on September 28, 1995. The claimant appealed that finding and the case was referred to the Office of Administrative Law

Judges for a formal hearing on November 1, 1995. On February 12, 1996, an administrative law judge issued a decision and order denying the claimant's request for modification. On March 27, 1997, the Board affirmed the judge's decision denying the request for modification. On May 19, 1997, Mr. Cunningham appealed the decision of the Board to the U.S. Court of Appeals for the Sixth Circuit. On May 5, 1998, the Court vacated the decision of the Board affirming the denial of benefits and remanded the case for further proceedings. The Board accordingly remanded the case to the Office of Administrative Law Judges for a hearing. I was then assigned the case and conducted a hearing on April 20, 2000. (DX 1, 53, 54, 62, 63, 64, 73, 77, 78, 86, 88, 92, 98, 100; ALJX 3, p. 1-5, 77).

Coal Mine Employment

The duration of a claimant's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. Claimant bears the burden of proof in establishing the length of his coal mine work. *See Shelesky v. Director, OWCP*, 7 BLR 1-34, 1-36 (1984); *Rennie v. U.S. Steel Corp.*, 1 BLR 1-859, 1-862 (1978). On his application for benefits, Mr. Cunningham alleged thirty-seven years of coal mine employment. The evidence in the record includes an employment history form, applications for benefits, and personnel records. (DX 1, 2, 3).

The Act fails to provide specific guidelines for computing the length of a miner's coal mine work. However, the Benefits Review Board consistently has held that a reasonable method of computation, supported by substantial evidence, is sufficient to sustain a finding concerning the length of coal mine employment. *See Croucher v. Director, OWCP*, 20 BLR 1-67, 1-72 (1996) (en banc)*; Dawson v. Old Ben Coal Co.*, 11 BLR 1-58, 1-60 (1988); *Niccoli v. Director, OWCP*, 6 BLR 1-910, 1-912 (1984). Thus, a finding concerning the length of coal mine employment may be based on many different factors, and one particular type of evidence need not be credited over another type of evidence. *Calfee v. Director, OWCP*, 8 BLR 1-7, 1-9 (1985).

At the hearing, the employer conceded that Mr. Cunningham worked for twenty-seven years in qualifying coal mine work. Based upon my review of the record, I credit claimant with

twenty-eight years and three quarters of coal mine employment. Mr. Cunningham last worked as an underground mine superintendent, which required working eight to fifteen hours per day. (Tr. 26). This job required Mr. Cunningham to climb silos to perform inspections, as well as do heavy walking at times. (Tr. 31-32).

Responsible Operator

In order to be deemed the responsible operator for this claim, Island Creek Coal Company must have been the last employer in the coal mining industry for which Mr. Cunningham had his most recent period of coal mine employment of at least one year, including one day after December 31, 1969. 20 C.F.R. §§ 725.492(a), 493(a). Mining records from Island Creek Coal Company and claimant's employment history forms establish that Island Creek Coal Company was the last employer to meet these conditions. (DX 2, 3). Therefore, I find that Island Creek Coal Company properly is designated as the responsible operator.

Pneumoconiosis and Related Issues

I. Medical Evidence

The medical evidence of record is as follows:

A. X-rays

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
7/21/74	DX 42	C. W. Rogers	Normal study
8/6/74	DX 42	S. E. Coffman	Lungs clear
10/6/75	DX 42	S. E. Coffman	Lungs clear
10/8/75	DX 42	J. L. Beck	No active pulmonary disease
10/20/76	DX 42	S. E. Coffman	Lungs clear
4/28/77	DX 42	S. E. Coffman	Lungs clear

5/13/78	DX 42	J. L. Beck	No active pulmonary disease
5/15/78	DX 42	A. Kriner	Lung fields clear of active process
5/17/78	DX 42	A. Kriner	Lung fields clear
7/28/78	DX 42	V. I. Pokorny	Lungs clear
6/21/79	DX 42	L. J. Wilkie	Heart and lungs normal
11/2/79	DX 42	R. Arendale	Lungs clear
7/29/81	DX 6	W. B. Blue	Lung fields clear; no active disease
11/9/81	DX 7	W. G. West	Coal workers' pneumoconiosis

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
11/9/81	DX 34	J. J. Renn/B-reader[1]	Completely negative
3/1/82	DX 28, p. 63	W. H. Anderson	No evidence of coal workers' pneumoconiosis
3/1/82	DX 29, p. 24	R. P. O'Neill	No evidence of coal workers' pneumoconiosis
3/1/82 (5/10/83)	DX 42	P. Franke/Board-certified radiologist and B-reader	0/0
3/1/82 (8/31/83)	DX 40	G. O. Kress/B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
4/22/82	DX 14	J. D. Stokes/Board-certified radiologist	1/0; p

[1]When evaluating interpretations of miners' chest x-rays, an administrative law judge may assign greater evidentiary weight to readings of physicians with superior qualifications. 20 C.F.R. § 718.202(a)(1); *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211, 1-213 (1985). The Benefits Review Board and the Sixth Circuit Court of Appeals have approved attributing more weight to interpretations of "B" readers because of their expertise in x-ray classification. *See Warmus v. Pittsburgh & Midway Coal Mining Co.* 839 F.2d 257, 261, n.4 (6th Cir. 1988); *Meadows v. Westmoreland Coal Co.*, 6 BLR 1-773, 1-776 (1984). A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2). Interpretations by a physician who is a "B" reader and is certified by the American Board of Radiology may be given greater evidentiary weight than an interpretation by any other reader. *See Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Sheckler v. Clinchfield Coal Co.*, 7 BLR 1-128, 1-131 (1984).

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
4/22/82 (3/18/83)	DX 12	W. S. Cole/Board-certified radiologist and B-reader	0/0
4/22/82 (3/23/83)	DX 37	Renn/B-reader	0/0
4/27/82	DX 42	V. J. Pokorny	Lungs clear
5/13/82	DX 28, p. 16	R. P. O'Neill	0/0
5/13/82 (7/1/82)	DX 28, p. 39	B. Felson/Board-certified radiologist and B-reader	No coal workers' pneumo-coniosis
5/13/82 (7/12/82)	DX 16	T. R. Marshall/B-reader	1/0; q/q
8/4/82	DX 26	J. L. Beck	Category 0
8/5/82	DX 30	F. H. Taylor	1/0
8/5/82 (3/4/83)	DX 35	J. F. Wiot/Board-certified radiologist and B-reader	0/0
8/5/82 (4/12/83)	DX 38	H. B. Spitz/Board-certified radiologist and B-reader	0/0
8/5/82 (5/2/83)	DX 39	B. Felson/Board-certified radiologist and B-reader	No coal workers' pneumoconiosis
10/4/82	DX 26	J. L. Beck	Pneumoconiosis, category 0
10/4/82	DX 10	W. C. Houser	1/0
10/4/82	DX 15, 17	S. B. Baker/Board-certified radiologist	1/0
10/4/82	DX 26	F. H. Taylor	Pneumoconiosis, 1/0, q
10/4/82 (11/25/82)	DX 13	W. S. Cole/Board-certified radiologist and B-reader	0/0
3/25/86	DX 45	W. H. Clapp	Increased interstitial markings

10/15/91 DX 71, p. 13 P. C. Trover Lungs are clear

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
5/4/93	EX 11	K. R. Pandit	Bilateral scarring with changes consistent with chronic obstructive pulmonary disease
5/4/93 (5/5/93)	EX 1	Ho	No active cardiopulmonary pathology
5/4/93 (8/24/95)	DX 93	E. N. Sargent/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
3/8/94	EX 12, p. 19	D. B. Rigby	Chronic obstructive pulmonary disease
7/5/95	EX 1	J. Esser	No active disease
7/5/95 (8/24/95)	DX 94	E. N. Sargent/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
7/5/95 (10/30/95)	EX 2	J. F. Wiot/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
7/5/95 (11/2/95)	EX 2	H. B. Spitz/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
7/5/95 (11/8/95)	EX 2	R. T. Shipley/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities

			consistent with pneumoconiosis
11/14/95	EX 3, p.28	J. W. Selby/B-reader	0/1, s/t

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
11/14/95 (11/25/98)	EX 4	J. F. Wiot/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
11/14/95 (12/4/98)	EX 6	H. B. Spitz/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
11/14/95 (12/15/98)	EX 6	C. M. Perme/Board-certified radiologist and B-reader	No coal workers' pneumoconiosis
11/14/95 (3/27/99)	EX 16	R. T. Shipley/Board-certified radiologist and B-reader	No coal workers' pneumoconiosis
6/18/96	EX 10, p. 69	D. Weber	Probable degree of obstructive pulmonary disease with no acute cardiopulmonary process
6/18/96 (12/17/99)	EX 19	J. F. Wiot/Board-certified radiologist and B-reader	Unreadable
6/20/96	EX 10, p. 73	D. Weber	Probable obstructive pulmonary disease with no significant change
6/20/96 (12/17/99)	EX 19	J. F. Wiot/Board-certified radiologist and B-reader	Unreadable
6/28/96 (6/29/96)	EX 10, p. 84	J. Esser	No acute infiltrates or effusions; no active disease
6/29/96 (12/17/99)	EX 19	J. F. Wiot/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities

			consistent with pneumoconiosis
7/15/96 (12/17/99)	EX 19	J. F. Wiot/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
10/7/96	EX 12, p. 20	J. L. Beck	No active pulmonary disease
10/8/96 (10/9/96)	EX 10, p. 59	J. Harpole	No acute abnormalities
10/8/96 (12/17/99)	EX 19	J. F. Wiot/Board-certified radiologist and B-reader	Unreadable
10/25/96	EX 10, p. 47	A. Perkins	No acute process
10/25/96 (12/17/99)	EX 19	J. F. Wiot/Board-certified radiologist and B-reader	Unreadable
12/27/96 (12/17/99)	Ex 19	J. F. Wiot/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
2/4/97 (2/5/97)	EX 10, p. 35	S. Eberly	Lung fields well expanded and clear
2/4/97 (12/17/99)	EX 19	J. F. Wiot/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
8/12/97	Ex 12, p. 21	R. W. Templin	No acute intrathoracic process
9/8/97	EX 12, p.22	P. C. Trover	Chronic obstructive pulmonary disease-lungs

			and pleural spaces otherwise clear
9/28/97	EX 10	J. Esser	No active disease
9/28/97 (12/17/99)	EX 19	J. F. Wiot/Board-certified radiologist and B-reader	Unreadable
10/7/97	EX 12, p. 23	G. J. Lawler	No acute disease
10/21/97	EX 10	J. Esser	No active disease

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
10/21/97 (12/17/99)	EX 19	J. F. Wiot/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
10/22/97	Ex 10, p. 22	K. Pandit	Clear lung fields bilaterally
11/19/97	Ex 12, p. 24	P. C. Trover	Lungs and pleural spaces are clear

B. Pulmonary Function Studies

DATE	EXHIBIT	HEIGHT[2]	AGE	FVC	FEV_1	MVV	TRACINGS	EFFORT
4/22/81	DX 8	70"	59	2.23	1.50	52	Yes	questionable
	[Dr. Branscomb found this test invalid because the tracings show absence of well formed conforming curves. (EX 5)]							
5/13/82	DX 9	71.25"	59	1.92	1.16	36	Yes	Fair
	[Dr. O'Neill invalidated this study due to inadequate effort. (DX 9)] [This study was found acceptable by Dr. Kraman. (DX 32)]							
8/5/82	DX 33	72"	60	2.53	1.57	47	Yes	Fair
	[Dr. Zaldivar found this test unacceptable due to the fact that three forced expiratory volume in one second obtained vary by more than 5 percent among themselves. (DX 27)]							
	[Dr. Kraman found this test acceptable. (DX 33)]							
9/27/82	DX 26	72"	60	2.60	1.60	54	Yes	Good

[2] Because the physicians conducting the pulmonary function studies noted heights varying between 70 and 72 inches, I must make a finding on the miner's height. *See Protopappas* v. Director, OWCP, 6 BLR 1-221, 1-223 (1983). I find that Mr. Cunningham's height is 72 inches, as this value is most frequently reported.

[This test was found invalid by Dr. Branscomb due to absence of maximum effort. (EX 5)]

DATE	EXHIBIT	HEIGHT	AGE	FVC	FEV_1	MVV	TRACINGS	EFFORT
10/4/82	DX 5	72"	60	3.06	1.85	62.6	Yes	Good
				(Pre-bronchodilator results)				
				3.29	2.16	73.4		
				(Post-bronchodilator results)				
	[Test found acceptable by Dr. Kraman. (DX 5)]							
10/23/91	DX 71	72"	69	1.58	1.06	–	Yes	Good
				(Pre-bronchodilator results)				
				2.35	1.40	-		
				(Post-bronchodilator results)				
	[Dr. Branscomb stated that the tracings were invalid because they were illegible. (EX 5)]							
7/5/95	DX 95	72"	73	2.59	1.11	-	No	Very Good
				(Pre-bronchodilator results)				
				3.00	1.33	-		
				(Post-bronchodilator results)				
	[Dr. Kraman found this test unacceptable due to insufficient number of FVC, FEV_1, or MVV. (DX 97)]							
11/14/95	EX 3	70"	73	2.76	1.09	47.0	Yes	Cooperative patient
				(Pre-bronchodilator results)				
				3.92	1.57	74.0		
				(Post-bronchodilator results)				
6/20/96	EX 11	72"	74	2.74	1.26	-	No	Good
				(Pre-bronchodilator results)				
				2.85	1.29	-		
				(Post-bronchodilator results)				

C. Arterial Blood Gas Studies

DATE	EXHIBIT	pCO_2 (mm.Hg.)	pO_2 (mm.Hg.)	RESTING/ AFTER EXERCISE
7/7/81	DX 30	39.2	67.8	Resting
3/1/82	DX 28, p.62	38.0	85.0	Resting
4/22/82	DX 11	36.6	85.7	Resting
5/13/82	DX 9	39.2	75.9	Resting

8/5/82	DX 26	32.0	81.0	Resting
10/4/82	DX 11	36.1	85.9	Resting
DATE	EXHIBIT	pCO_2 (mm.Hg.)	pO_2 (mm.Hg.)	RESTING/ AFTER EXERCISE
5/11/93	EX 1	36.0	85.0	Resting
11/14/95	EX 3	39.0	74.0	Resting
6/18/96	EX 11, p. 24	29.0	129.0	Resting
10/21/97	EX 11, p. 41	36.0	92.0	Resting

D. Medical Reports

Mr. Cunningham was admitted to the Methodist Hospital on July 29, 1981 and was discharged on August 2, 1981. Dr. Willis B. Blue prepared a discharge summary which diagnosed the miner with unstable angina pectoris associated with tachybrady syndrome, requiring a permanent cardiac pacemaker, moderate severe chronic lung disease with probability of coal workers' pneumoconiosis, acute and chronic prostatitis, status post two previous coronary artery bypass surgeries, and chronic angina. Dr. Blue indicated that Mr. Cunningham had a class 5 physical impairment which means the miner has severe limitation of his functional capacity and was incapable of minimal, sedentary activity. Dr. Blue also noted that the miner had a class 3 cardiac impairment and that his condition arose out of his coal mine employment. (DX 6).

Dr. William G. West examined the miner on December 4, 1981 and issued a report on December 15, 1981. The physician performed a physical examination and a chest x-ray. Dr. West noted 35 years of coal mine employment, 25 of which were underground. He did not note a smoking history. Dr. West diagnosed the miner with coal workers' pneumoconiosis due to coal mine employment and stated that Mr. Cunningham was disabled for coal mine employment due to shortness of breath from his coal workers' pneumoconiosis. (DX 7).

On March 1, 1982, Dr. William Anderson, a Board-certified medical examiner, internist, and pulmonologist, examined the miner. The physician performed a physical examination, chest x-ray, an arterial blood gas study, and an electrocardiogram. Mr. Cunningham would not submit to a pulmonary function study due to his heart condition. Dr. Anderson noted a coal mine employment history of 40 years, all underground. Further, he noted that the miner began smoking at age 18 at the rate of one pack per day, but that he had cut back to three to four cigarettes per day. The physician diagnosed Mr. Cunningham with arteriosclerotic heart disease with status post-op coronary surgery and noted the presence of a pacemaker. Dr. Anderson indicated that he found no evidence of coal workers' pneumoconiosis or silicosis. (DX 28, p. 73).

On April 22, 1982, Dr. Valentino Simpao examined Mr. Cunningham. He performed a physical examination and a pulmonary function study. Dr. Simpao noted that the miner had 37 years of coal mine employment, all underground. Dr. Simpao noted that the miner had open heart surgery in May 1981. In addition, he noted Mr. Cunningham had a history of smoking one pack per day, but that in the two years prior to the examination, he had cut back to four to five cigarettes per day. Dr. Simpao diagnosed the miner with pulmonary fibrosis with chronic bronchitis due to coal mine employment. He indicated that the miner's pulmonary disability appeared to be total and that he was unable to do any physical activity due to a combination of his heart and lung problems. (DX 8, 30).

Dr. Richard O'Neill, who was Board-certified by the Irish and English Board of Internal Medicine, examined the miner on May 13, 1982. The physician performed a physical examination, chest x-ray, a pulmonary function study, and an arterial blood gas study. He noted Mr. Cunningham smoked one pack of cigarettes per day most of his adult life and that he quit in 1982. Further, he reported that the miner stated he worked 40 years in underground coal mine employment. Dr. O'Neill diagnosed Mr. Cunningham with mild obstructive airway disease, chronic bronchitis, arteriosclerotic cardiovascular disease, history of myocardial infarction, coronary insufficiency, status post coronary artery bypass graft, permanent pacemaker, and status post-op cholecystectomy. (DX 9).

Dr. Simpao testified by deposition on June 22, 1982. The physician reiterated his findings from his examination and further opined that the miner had coal workers' pneumoconiosis

based upon x-ray findings. Additionally, Dr. Simpao noted that the pulmonary function study showed restrictive and obstructive airway disease. The physician opined that Mr. Cunningham was disabled due to heart and lung problems and that he would not pass him for underground coal mine employment. Dr. Simpao indicated that the miner's overall outlook was totally disabled. Further, the physician stated he would not recommend him for employment due to his colostomy, heart problems, and arthritis. (DX 30, p. 3-25).

Dr. Blue, the miner's family physician, was deposed on July 9, 1982. Dr. Blue indicated he had been treating the miner for breathing difficulties since May 14, 1981. The physician was not sure how much the miner smoked, but he noted that the miner smoked since age 10. Dr. Blue noted that Mr. Cunningham had a significant amount of chronic obstructive pulmonary disease with asthmatic bronchitis, a percentage of which was related to coal dust exposure. The physician noted that the miner's heart and lung disability were closely related. Further, he stated that Mr. Cunningham's chronic obstructive pulmonary disease possibly or probably was coal workers' pneumoconiosis. Dr. Blue did not believe that Mr. Cunningham could perform coal mine employment because his breathing condition would be made worse. He noted that the miner could not walk stairs. (DX 30, p. 39-77).

Dr. Joseph Stokes, a Board-certified radiologist and B-reader, interpreted Mr. Cunningham's April 22, 1982 x-ray and diagnosed pneumoconiosis, category 1/0. Dr. Stokes opined that employers in the area would not hire him due to the fact that he had pneumoconiosis. (DX 30, p. 26-36).

Dr. O'Neill also testified by deposition on July 14, 1982. Dr. O'Neill opined that the miner had a mild obstructive airways disease and chronic bronchitis, both due to cigarette smoking. The physician also noted that Mr. Cunningham's mild obstructive airway disease and chronic bronchitis would be in part work related. Dr. O'Neill stated that the miner did not have coal workers' pneumoconiosis. (DX 28, p. 2-25).

Dr. Frank H. Taylor, a Board-certified internist and pulmonologist, examined the miner on August 5, 1982. Dr. Taylor also performed a chest x-ray, a pulmonary function study, and an arterial blood gas study. He noted a coal mine employment history of 37 years underground and a smoking

history of 40 pack years. Dr. Taylor diagnosed Mr. Cunningham with borderline coal workers' pneumoconiosis, chronic bronchitis, chronic obstructive pulmonary disease, severe arteriosclerotic cardiovascular disease with a permanent pacemaker and previous coronary artery bypass surgeries. Dr. Taylor indicated that the miner had a moderate impairment which was related predominantly to chronic obstructive pulmonary disease from cigarette smoking and his arteriosclero- tic heart disease. The physician opined that Mr. Cunningham had pulmonary and cardiac impairments, but that his impairment related to his coal mine employment was not disabling. (DX 26).

Dr. Benjamin Felson, a Board-certified radiologist and B-reader, testified by deposition on August 26, 1982. Dr. Felson reviewed Mr. Cunningham's May 13, 1982 x-ray and interpreted it as containing no evidence of coal workers' pneumoconiosis. (DX 28, p. 26-43).

Dr. Anderson was deposed on August 27, 1982. In his deposition he reiterated his findings from his previous examination and stated that the miner's complaints of shortness of breath and cough were due to his arteriosclerotic heart disease and that he did not have a respiratory impairment separate from his cardiovascular disease impairment. Further, Dr. Anderson opined that he could not give an opinion regarding whether the miner had a pulmonary impairment due to the fact that he could not obtain pulmonary function studies for Mr. Cunningham. However, from his examination of Mr. Cunningham, the physician opined that the miner was disabled to do hard labor, but that the disability was due to arteriosclerotic heart disease. Dr. Anderson found no evidence of coal workers' pneumoconiosis. (DX 28, p. 44-74; DX 44).

Dr. Taylor testified by deposition on September 29, 1982. The physician reiterated the findings contained in his report and also stated that based upon the miner's work history and chest x-ray, he opined Mr. Cunningham had coal workers' pneumoconiosis, category 1/0. Further, he diagnosed the miner with chronic bronchitis due to smoking, chronic obstructive pulmonary disease and arteriosclerotic heart disease. Dr. Taylor did indicate that some of the miner's chronic obstructive pulmonary disease was due to his coal mine employment. The physician stated that he believed the miner had a moderate obstructive and restrictive impairment, but

that he was not disabled from performing his last coal mine job. (DX 30, p. 91-123; 44).

Dr. William Houser, a Board-certified internist with subspecialties in pulmonary disease and critical care medicine, examined the miner on October 4, 1982. Dr. Houser performed a physical examination, a chest x-ray, a pulmonary function study, an arterial blood gas study, and an electrocardiogram. The physician noted a coal mine employment history of 39 years, all underground, and a smoking history of 40 years at the rate of one pack per day, but that he stopped smoking three months prior to the examination. Dr. Houser diagnosed Mr. Cunningham with coal workers' pneumoconiosis, chronic bronchitis caused by coal dust exposure, chronic obstructive pulmonary disease, which may have been exacerbated, and arteriosclerotic heart disease. Dr. Houser indicated that his conclusions were based upon chest x-ray and the miner's coal dust exposure. Further, he stated that the pulmonary function studies showed a moderately severe obstruction. (DX 10, 11).

Dr. O'Neill was deposed on December 21, 1982. Dr. O'Neill reiterated his findings contained in his report and diagnosed the miner with arteriosclerotic cardiovascular disease, coronary insufficiency, history of myocardial infarction or heart attack. The physician stated that Mr. Cunningham had bronchial and obstructive airway disease, which was probably due to smoking, but that he would not be prevented from doing work up to the level of manual labor. Dr. O'Neill opined that the miner retained the respiratory capacity to perform the job of a superintendent or general mine foreman. The physician indicated that Mr. Cunningham did not have any other lung disease and that he was not totally disabled for his last coal mine employment due to any chronic dust disease. However, the miner's cardiovascular disease would prevent him from performing his last coal mine employment. Dr. O'Neill opined that the miner's cardiovascular disease was unrelated to his coal mine employment and that he did not have coal workers' pneumoconiosis. (DX 29).

Dr. George O. Kress reviewed the medical evidence of record and issued a report on January 26, 1983. Dr. Kress opined that there is not sufficient evidence to justify a diagnosis of coal workers' pneumoconiosis. He indicated that the miner's arterio- sclerotic cardiovascular disease was a

significant contributing factor to his shortness of breath and chest pain. Dr. Kress diagnosed Mr. Cunningham with chronic bronchitis due to many years of cigarette smoking. The physician noted that if one were to only consider his respiratory impairment, excluding his severe arteriosclerotic cardiovascular disease, Mr. Cunningham would retain the respiratory capacity to perform his usual coal mine employment. (DX 31).

The record contains a letter from Dr. William Clapp dated May 20, 1986 in which the physician stated that Dr. Clapp had treated the miner since February 18, 1982 for breathing trouble. Dr. Clapp indicated Mr. Cunningham has dyspnea on exertion and recurrent episodes of bronchitis and that he had an asthmatic component to his breathing difficulty. Dr. Clapp opined the miner had significant chronic obstructive pulmonary disease with chronic bronchitis, emphysema, and interstitial fibrosis. The physician noted that he feels the miner's lung disease did contribute to his disability. (DX 45).

Dr. Kevin Young, who is Board-certified in internal medicine, issued a letter on May 27, 1986 which indicated that the miner suffers from significant heart and lung disease in the form of coronary artery disease and severe chronic lung disease. Further, the physician stated that it appears that Mr. Cunningham has a severe functional limitation and that he was more disabled from his lung problem than his heart problem. (DX 46, 48).

The record contains medical reports from Drs. William Clapp and Douglas Johnson, the claimant's treating physicians, dated from February 17, 1992 through November 24, 1997. These records contain multiple diagnoses including acute bronchitis, chronic bronchitis, chronic obstructive pulmonary disease with acute exacerbation and tobacco abuse. There is no mention of pneumoconiosis or that any of the miner's conditions were in any way related to the inhalation of coal dust. (EX 9-12).

Dr. Kuldeep Pandit examined Mr. Cunningham on May 6, 1993. He performed a physical examination and a chest x-ray. Dr. Pandit noted 40 years of coal mine employment and that the miner smoked one pack per day for 53 years. The physician diagnosed the miner with dyspnea on exertion with mild activity and acute bronchitis with exacerbation of chronic asthmatic bronchitis. Dr. Pandit performed follow up examinations on several occasions beginning on May 11, 1993

and continuing through July 13, 1995. Dr. Pandit interpreted Mr. Cunningham's May 11, 1993 pulmonary function study as showing a mild obstructive impairment and stated that the findings are suggestive of significant underlying reversible airway disease. Further, Dr. Pandit opined that Mr. Cunningham had moderate to severe chronic obstructive pulmonary disease and that his coal mine employment and smoking history seem to have contributed to the miner's pulmonary disease. (DX 92; EX 11).

The record contains a letter from Dr. Hector Garcia which is dated August 3, 1995. Dr. Garcia noted that Mr. Cunningham had a history of coronary artery disease and that he had coronary artery bypass grafting. The physician also indicated that the miner had a history of a permanent pacemaker implantation. Dr. Garcia diagnosed Mr. Cunningham with chronic obstructive pulmonary disease. The physician made no reference as to whether the miner's chronic obstructive pulmonary disease was caused by his coal dust exposure. (DX 92).

On November 14, 1995, Dr. Jeffrey Selby, who is Board-certified in internal medicine with a subspecialty in pulmonol- logy, examined the miner. Dr. Selby performed an examination, a pulmonary function study, an arterial blood gas study, and an electrocardiogram. The physician reported that the miner had 35 years of coal mine employment and a smoking history of 25 pack years. Dr. Selby opined that Mr. Cunningham did not have coal workers' pneumoconiosis or any pulmonary disease or respiratory impairment resulting from coal mine employment. The physician opined that the miner showed a severe obstructive disorder, but that he had good responsiveness to a bronchodilator. Further, he stated that Mr. Cunningham had a severe degree of emphysema and chronic obstructive pulmonary disease due to smoking and asthma, which was due to an inherited tendency. Dr. Selby noted that the miner had a serious and severe cardiac disease and had Mr. Cunningham not smoked cigarettes or had bronchial asthma, which are both unrelated to coal mine employment, he would have essentially normal pulmonary function and could perform all previous coal mine employment. (EX 3).

The miner was admitted to Community Methodist Hospital on numerous occasions from June 18, 1996 through October 1, 1997. During this period Mr. Cunningham was diagnosed with various disorders pertinently including atrial fibrillation with a

rapid ventricular response, chronic obstructive pulmonary disease with exacerbation, chest pain, coronary artery disease, cardiomyo- pathy, chronic obstructive pulmonary disease with reactive airway disease, congestive heart failure, symptomatic hypotension and emphysema. (EX 10).

Mr. Cunningham was also admitted to Union County Methodist Hospital at various times during October 1997. During these admissions, the diagnoses included congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, intermittent atrial fibrillation and hypotension. (EX 9).

Dr. W. K. C. Morgan reviewed Mr. Cunningham's medical records and prepared a consultative report on December 9, 1998. Dr. Morgan has an FRCP Edinburgh degree, which is roughly the British and Canadian equivalent to the U. S. certification in internal medicine with a subspecialty in pulmonary medicine. The physician indicated that the April 22, 1982 pulmonary function study performed on the miner was invalid because they were aborted prematurely. However, he believed the MVV showed some restrictive impairment and possible minimal obstruction. Further, he contends the August 5, 1982 and the September 27, 1982 pulmonary function studies are also invalid due to submaximal inspiration. Dr. Morgan opined that Mr. Cunningham did not have coal workers' pneumoconiosis, but that he does have a significant obstructive impairment. The physician contended the miner had a moderate to moderately severe airway obstruction which was a consequence of cigarette smoking and is due in minor part to allergic diathesis, which led to the development of asthma. However, Dr. Morgan contends that his impairment is not related to the miner's coal mine employment. The physician opined Mr. Cunningham was permanently and totally disabled and that some of his disability was related to his heart disease. (EX 7, 17).

Dr. Ben Branscomb, who is Board-certified in internal medicine, reviewed the medical evidence of record and issued a consultative report on December 12, 1998. Dr. Branscomb opined Mr. Cunningham did not have coal workers' pneumoconiosis. The physician stated the miner's pulmonary function studies showed a moderately severe airways obstruction and no restrictive impairment. Dr. Branscomb opined that a restrictive impairment is indicative of asthma or asthmatic bronchitis which is seen in cigarette smokers and

that the findings of Mr. Cunningham's pulmonary function studies do not show the characteristics of coal workers' pneumoconiosis. The physician stated that the miner's respiratory impairment was not attributable to coal workers' pneumoconiosis and was in no way caused by, aggravated by, or influenced by coal dust exposure. Further, he noted that the miner was permanently and totally disabled, but that it was due to coronary artery disease and an additional component of his impairment was caused by chronic asthmatic bronchitis or chronic obstructive pulmonary disease which was caused by an inborn tendency to asthma and due to smoking. (EX 5, 15).

Dr. James R. Castle, who is Board-certified in internal medicine and pulmonary disease by the National Institute for Occupational Safety and Health, reviewed Mr. Cunningham's medical records and issued a report on January 13, 1999. The physician opined that the miner did not have coal workers' pneumoconiosis or any pulmonary disease or respiratory impairment resulting from coal mine employment. Dr. Castle indicated that Mr. Cunningham had a severe degree of emphysema and chronic obstructive pulmonary disease, as well as asthma and severe cardiac disease. The physician opined that the miner was permanently and totally disabled as a result of tobacco induced chronic obstructive pulmonary disease and bronchial asthma, and coronary artery disease. All of which, Dr. Castle opined, were unrelated to his previous coal mine employment. (EX 8, 15).

Dr. Morgan issued a supplemental report on June 1, 1999 and stated that his opinion from his December 9, 1998 report remained unchanged. Further, he indicated that Mr. Cunningham did have moderately severe chronic obstructive pulmonary disease. (EX 13).

Dr. Castle issued a supplement to his January 13, 1999 report on June 4, 1999. Dr. Castle reiterated that Mr. Cunningham did not have coal workers' pneumoconiosis or any chronic dust disease of the lungs or the sequelae thereof, caused by, contributed to, or substantially aggravated by coal mine dust exposure. The physician opined that the miner was permanently and totally disabled but that it was not associated with coal mine employment or coal dust exposure. (EX 14).

Dr. Selby also testified by deposition on June 21, 1999. Dr. Selby reiterated the findings from his previous report and

clarified that he does not believe the miner had coal workers' pneumoconiosis or any respiratory disease due to, related to, or aggravated by occupational exposure to coal dust. Further, Dr. Selby testified that the miner did not have a functional disability due to, related to, or aggravated by occupational exposure to coal dust. The physician based his opinions on the combination of the medical examination, medical history and laboratory findings. (EX 21).

Dr. Morgan testified by deposition on June 29, 1999. Dr. Morgan testified that Mr. Cunningham did not have coal workers' pneumoconiosis, that his heart disease is not caused in any way by coal dust exposure, and that the miner's respiratory impairment was entirely a consequence of cigarette smoking. (EX 17).

Dr. Branscomb reviewed additional medical records and on December 5, 1999, supplemented his December 12, 1998 decision. The physician stated that his original opinions remained unchanged. (EX 18).

II. Discussion

Modification

Section 725.310 provides that a claimant may file a petition for modification within one year of the last denial of benefits. Modification petitions may be based upon a change in condition or a mistake in a determination of fact. 20 C.F.R. § 725.310(a). On July 3, 1995, Mr. Cunningham timely requested modification of the denial dated May 30, 1995. (DX 86, 88, 92).

In deciding whether claimant has established a change in condition, I must "perform an independent assessment of the newly submitted evidence, in conjunction with evidence previously submitted, to determine if the weight of the new evidence is sufficient to establish the element or elements which defeated entitlement. . . ." *Napier v. Director, OWCP*, 17 BLR 1-111, 1-113 (1993). *See also Nataloni v. Director, OWCP*, 17 BLR 1-82, 1-84 (1993). To decide whether the prior decision contains a mistake in a determination of fact, I must review all the evidence of record, including evidence submitted since the most recent denial. New evidence, however, is not a prerequisite to modification based upon a

mistake of fact. *Nataloni*, 17 BLR at 1-84; *Kovac v. BCNR Mining Corp.*, 14 BLR 1-156, 1-158(1990), *aff'd on recon.* 16 BLR 1-71, 1-73 (1992). *See also O'Keefe v. Aerojet-General Shipyards*, 404 U.S. 254, 257 (1971). Rather, the factfinder is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971).

Because Mr. Cunningham filed his request for modification after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations, claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989).

In the prior denial, the Benefits Review Board affirmed the administrative law judge's January 20, 1994 decision in which it was determined that the claimant did not have a totally disabling respiratory or pulmonary impairment arising from coal mine employment. The evidence submitted since that decision includes hospital records, examination reports, pulmonary function studies, and arterial blood gas studies. Therefore, I will consider the newly submitted evidence and consider it in conjunction with the previously submitted evidence to determine if the weight of the evidence is sufficient to demonstrate an element or elements of entitlement which were previously adjudicated against the claimant. Based upon my review of the newly submitted evidence since the prior final denial, I find the claimant has established a change in condition by proving he had a totally disabling respiratory impairment at the time of his death.

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(2). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 BLR 1-11, 1-15 (1991). Section 718.204(c) provides several criteria for establishing total disability.

Under this section, I must first evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195, 1-198 (1987).

Under Sections 718.204(c)(1) and (c)(2), total disability may be established with qualifying pulmonary function studies or arterial blood gas studies.[3]

Mr. Cunningham has established a change in condition by proving that he suffered from a totally disabling respiratory impairment at the time of his death under Section 718.204(c)(1). Since the prior denial, three pulmonary function studies and three arterial blood gas studies have been placed in the record. Of the three newly submitted pulmonary function studies, I find that the July 5, 1995 and the June 20, 1996 studies are invalid due to the fact that these studies were not accompanied by three tracings. *See Estes v. Director, OWCP*, 7 BLR 1-414 (1984). Further, Dr. Kraman also deemed the July 5, 1995 pulmonary function study as unacceptable due to an insufficient number of FVC, FEV_1, and MVV values. However, the one remaining pulmonary function study dated November 14, 1995 produced qualifying values. The patient was also noted to be cooperative during the performance of the November 14, 1995 study. Therefore, I find that the newly submitted pulmonary function study evidence weighs in favor of a finding of total disability. The pulmonary function studies which were in the record at the time of the prior denial all produced qualifying values. Therefore, I find that the new, as well as the old, pulmonary function study evidence weighs in favor of a finding of total disability.

The three newly submitted arterial blood gas studies, as well as the previously submitted arterial blood gas studies, all produced non-qualifying values. Hence, I find that the

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[3]A "qualifying" pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(c)(1) and (c)(2). A "non-qualifying" test produces results that exceed the table values.

arterial blood gas studies evidence does not weigh in favor of a finding of total disability.

Section 718.204(c)(3) provides that a claimant may prove total disability through evidence establishing cor pulmonale with right-sided congestive heart failure. This section is inapplicable to this claim because the record contains no such evidence.

Where a claimant cannot establish total disability under subparagraphs (c)(1), (c)(2), or (c)(3), Section 718.204(c)(4) provides another means to prove total disability. Under this section, total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable and gainful work.

Upon review of the evidence submitted since the prior denial, Drs. Morgan, Branscomb, and Castle all opined the miner was permanently and totally disabled from a pulmonary standpoint. I accord all of these physicians great weight based on their heightened qualifications. *See Warman v. Pittsburgh & Midway Coal Co.*, 8 BLR 1-390 (1985). Dr. Morgan has a degree which is roughly the British and Canadian equivalent to the U.S. certification in internal medicine and pulmonary disease, Dr. Branscomb is Board-certified in internal medicine and Dr. Castle is Board-certified in internal medicine and pulmonary disease. Further, Dr. Selby does not indicate whether the miner was permanently and totally disabled but does recognize that he suffered from a severe obstructive disorder. Dr. Garcia does not offer an opinion as to the miner’s disability. Of the narrative medical opinion evidence in existence at the time of the prior denial, Drs. Kress, Pandit, Clapp, and Young do not specifically state whether Mr. Cunningham retained the respiratory capacity to perform his usual coal mine employment at the time of his death.

Only Drs. O’Neill and Taylor opined that Mr. Cunningham was not totally disabled from a respiratory impairment. However, Dr. O’Neill testified that the miner’s cardiovascular disease would prevent him from performing his last coal mine employment. Dr. Taylor also recognized Mr. Cunningham had a

moderate obstructive and restrictive impairment. Drs. Blue, West, Anderson, and Simpao also concur that Mr. Cunningham was disabled from his previous coal mine employment. I give greater weight to the opinions of Drs. Morgan, Castle, Branscomb, Blue, West, Anderson, and Simpao due to the fact that their opinions are better supported by the objective medical evidence. *Minnich v. Pagnotti Enterprises, Inc.*, 9 BLR 1-89, 1-90 n. 1 (1986).

Considering the newly submitted medical opinion evidence with the previously submitted medical opinion evidence, I find that the medical opinion evidence weighs in favor of a finding of total disability. Further, although the arterial blood gas study evidence weighs against a finding of total disability, the preponderance of the pulmonary function study evidence and the narrative medical opinion evidence establish that Mr. Cunningham has shown a change in condition and that he established under Section 718.204(c)(1) and (4) that he suffered from a totally disabling respiratory disease at the time of his death.

Because the claimant has established a change in condition, I will now review the entire record to determine the miner's entitlement to benefits.

Entitlement

The Act defines "pneumoconiosis" as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP,* 12 BLR 1-6 (1988); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (*en banc*).

Thirty-five interpretations of twenty x-rays have been submitted in the record since the previous denial. None of

these interpretations is positive for pneumoconiosis. Eighteen of these interpretations were made by dually-qualified physicians and one was made by a B-reader. Hence, I find that the newly submitted x-ray interpretations do not weigh in favor of a finding of pneumoconiosis.

The older x-ray evidence of record contains forty-two interpretations of twenty-four x-rays. Of these interpretations, sixteen were negative, eight were positive and eighteen were silent as to the existence of pneumoconiosis. Of the positive interpretations, none was by dually-qualified physicians. The April 22, 1982 and the October 4, 1982 x-rays were interpreted as positive by Board-certified radiologists. The May 13, 1982 x-ray was interpreted as positive by a B-reader. However, of the sixteen negative interpretations, eight of the interpretations were by dually-qualified physicians. Due to the superior radiographical qualifications of the majority of the physicians who interpreted the old x-ray evidence, I find the old x-ray evidence does not support a finding of pneumoconiosis.

When considering the new x-ray evidence in light of the older x-ray interpretations, I find the negative readings constitute the majority of interpretations and are verified by more, highly-qualified physicians. Therefore, I find the x-ray evidence does not establish that Mr. Cunningham suffered from pneumoconiosis.

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. This section is inapplicable herein because the record contains no such evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions applies to this claim, claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides the fourth and final way for a claimant to prove that he has pneumoconiosis. Under this section, a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion may support the presence of the disease if it is supported by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 9 BLR 1-22, 1-24 (1986).

Since the prior denial, two examination reports, three consultative reports, two supplemental reports, and two depositions, as well as various hospital records, have been placed in the record. None of the records or physicians' opinions contains a diagnosis indicating Mr. Cunningham had coal workers' pneumoconiosis. Dr. Garcia diagnosed the miner with chronic obstructive pulmonary disease, but was silent as to whether the disease was related to Mr. Cunningham's coal mine employment. The hospital records from Community Methodist Hospital contain diagnoses that show the miner was afflicted with many disorders including chronic obstructive pulmonary disease and emphysema. The records from Union County Methodist Hospital listed several diagnoses including chronic obstructive pulmonary disease. Drs. Selby, Morgan, Branscomb and Castle, all highly-qualified physicians, opined that the miner does not have coal workers' pneumoconiosis. I give great weight to the opinons of these physicians due to their heightened qualifications. Of the newly submitted medical opinion evidence, no physician diagnosed the miner with coal workers' pneumoconiosis. Therefore, I find these opinions do not establish the existence of pneumoconiosis.

Of the previously submitted medical opinion evidence, Drs. Blue, West, Simpao, Taylor, Pandit, and Houser opined that the claimant suffered from pneumoconiosis, while Drs. Anderson and O'Neill indicated that Mr. Cunningham did not suffer from the disease. Drs. Clapp, Johnson, and Young diagnosed the claimant with lung disease, but did not attribute his lung disease to the miner's coal mine employment.

Upon review of the old narrative medical opinion evidence, I note that Dr. Blue's opinion that Mr. Cunningham

had moderate severe chronic lung disease with "probability" of coal workers' pneumoconiosis is equivocal and entitled to less weight. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995). I also give less weight to Dr. West's opinion that the miner had coal workers' pneumoconiosis because he failed to note a smoking history and hence, it is not well-reasoned. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(*en banc*). Further, I find Dr. Pandit's May 6, 1993 opinion that the miner's moderate to severe chronic obstructive pulmonary disease "seems" to have contributed to his pulmonary disease is also equivocal and is entitled to less evidentiary weight.

I give great weight to the opinions of Drs. Anderson and O'Neill that the miner did not have coal workers' pneumoconiosis based upon their superior qualifications, the fact that they defended their opinions through deposition testimony, and because their opinions are supported by the miner's treating physicians, Drs. Clapp and Johnson. Although Drs. Clapp and Johnson diagnosed the miner with significant chronic obstructive pulmonary disease with chronic bronchitis, emphysema, interstitial fibro-sis and asthma, neither of these physicians attributed Mr. Cunningham's lung disease to his coal mine employment. I give his treating physicians great weight as they are more likely to be familiar with the miner's condition. *Onderko v. Director, OWCP*, 14 BLR 1-2 (1989).

I find that the old medical opinions of record do not establish the existence of pneumoconiosis. When considering the new narrative medical evidence in light of the old narrative medical evidence, I give greater weight to the opinion of Dr. Selby that the claimant did not have coal workers' pneumoconiosis as he performed the most recent physical examination of the miner, which is likely to be the most accurate evaluation of the miner's condition at the time of his death. *Gillespie v. Badger Coal Co.*, 7 BLR 1-839 (1985).

Further, Dr. Selby's opinion is well-reasoned as he supports his opinion by setting forth the clinical findings, observations, and facts upon which he based his diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). Dr. Selby further defended his opinion through deposition testimony. When considering the new medical opinion evidence in light of the old narrative medical opinion evidence, I find Mr. Cunningham has failed to establish the existence of

pneumoconiosis. Moreover, the weight of the evidence, both like and unlike, does not support a finding of pneumoconiosis under Section 718.202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569 (6th Cir. 2000); *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.2d 22, 24-25 (3rd Cir. 1997).

The administrative law judge and Benefits Review Board found with respect to Mr. Cunningham's original claim that the evidence proved he had pneumoconiosis. I find the weight of this record proves that finding was erroneous. Thus, a mistake of fact is found regarding the existence of pneumoconiosis. Because the claimant has failed to prove that he suffered from pneumoconiosis, this claim cannot succeed. Regardless, even if the evidence had established this element, it fails to prove another requisite element of entitlement, that claimant's totally disabling respiratory impairment is due to pneumoconiosis.

As previously discussed, I find that Mr. Cunningham has established that he suffered from a totally disabling respiratory impairment at the time of his death under Section 718.204(c)(1) and (4). Although the evidence indicates that the miner was totally disabled from a respiratory standpoint, the claimant must also establish that his total disability was due to pneumoconiosis. 20 C.F.R. § 718.204(b). To satisfy this requirement, the United States Court of Appeals for the Sixth Circuit requires a claimant to prove that his totally disabling respiratory is due "at least in part" to his pneumoconiosis. *Adams v. Director, OWCP*, 886 F.2d, 818, 825 (6th Cir. 1989). This means the miner "must affirmatively establish that pneumoconiosis is a contributing cause of some discernable consequence to his totally disabling respiratory impairment. The miner's pneumoconiosis must be more than merely a speculative cause of his disability." *Peabody Coal Co. v. Smith,* 127 F.3d 504, 507 (6th Cir. 1997).

Of the newly submitted evidence regarding causation of total disability, none of the physicians opined that Mr. Cunningham's totally disabling respiratory impairment was due to pneumoconiosis. Therefore, I find that the newly submitted evidence relating to causation of total disability does not weigh in favor of a finding that the miner's totally disabling respiratory impairment was due to pneumoconiosis.

When reviewing the evidence that was in existence at the time of the previous denial, only one physician, Dr. West, specifically indicated that Mr. Cunningham's respiratory impairment was due to pneumoconiosis. Dr. Anderson stated the miner was disabled from performing hard labor due to his heart disease. Dr. Simpao opined Mr. Cunningham was totally disabled and that he would not recommend him for employment due to the miner's colostomy, heart problems, and cardiovascular disease. Dr. O'Neill indicated that the miner was totally disabled due to cardiovascular disease. Dr. Kress stated that aside from the miner's heart disease, Mr. Cunningham would retain the capacity to perform his usual coal mine employment. Dr. Clapp did note that the miner's lung disease contributed to his disability, but he did not indicate whether his lung disease was related to the miner's coal mine employment. Dr. Houser did not offer an opinion as to the causation of the miner's disability.

I find that the opinion of Dr. West is entitled to less weight due to the fact that his opinion is not well-documented. Dr. West did not indicate what, if any, objective tests were performed on the miner. *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). I give greater weight to the opinions of Drs. Anderson and O'Neill due to their heightened qualifications and based on the fact that these physicians' opinions are better supported by more extensive documentation than the opinion of Dr. West, who only documented that he performed a physical examination and a chest x-ray. *See Sabett v. Director, OWCP*, 7 BLR 1-229 (1984). Therefore, I find that the old evidence regarding the cause of the miner's respiratory impairment does not weigh in favor of a finding that his impairment was due to pneumoconiosis.

When viewing the newly submitted evidence regarding causation of total disability in light of the old evidence, I give greater weight to Dr. Selby's opinion based on the fact that he performed the most recent examination of the miner. *Gillespie, supra*. Further, I also give greater weight to the opinions of Drs. Morgan, Branscomb, and Castle, who all opined that the miner's totally disabling respiratory impairment was not related to his coal mine employment. I find that these physicians' opinions are supported by more extensive documentation due to the fact that they reviewed all of the medical evidence and are likely to have the most complete picture of the miner's condition. *See Sabett, supra*.

Therefore, I find the evidence regarding causation of the miner's totally disabling respiratory impairment does not weigh in favor of a finding that Mr. Cunningham's respiratory impairment was due to pneumoconiosis.

In sum, the evidence does not establish the existence of pneumoconiosis or a totally disabling respiratory impairment due to pneumoconiosis. Accordingly, the claim of Ragon Cunningham must be denied.

Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to claimant for legal services rendered in pursuit of the claim.

ORDER

The request for modification by Ragon Cunningham is denied.

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DONALD W. MOSSER
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Workers' Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601. See 20 C.F.R. §§ 725.478 and 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building,

Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.